STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER HOUSE	2216 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for State Residential Licensure Survey. Survey Dates: February 21, 22, 23, 2011 Facility Number: 004444 Provider Number: 004444 AIM Number: N/A Survey Team: Patti Allen, BSW TC Diane Dierks, RN Leia Alley, RN (February 21, 22, 2011) Census Bed Type: Residential: 10 Total: 10 Census Payor Type: Other: 10 Total: 10 Sample: 7 These State Residential Findings are in accordance with 410 IAC 16.2. Quality review completed on March 2, 2011 by Bev Faulkner, RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0090	Based on observation, interview and record review, the facility failed to report to Indiana State Department of Health the call light system was not working. This affected all residents in the facility. Findings included: On the following date and time, the following observation was made: 2/23/11 at 9:50 a.m. - Resident # 1 was in her room sitting in a chair watching television. The room contained two call lights with pull strings attached. One call light was on the wall at the head of the bed and the second call light was located in the bathroom. The resident indicated that she didn't think the call lights were working. The call light by the bed was activated by this surveyor at 10:24 a.m. This surveyor exited Resident # 1's room at 10:40 a.m. and waited in the hall outside of the resident's room until 10:45 a.m. Staff did not respond to the call light. A document, dated 2/4/11, from the Staff Communication book provided by the Wellness Director on 2/23/11 at 2:30 p.m., included, but was not limited to, the following: "Attention staff please check residents	R0090	**R 090 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The call light system was replaced and operational on March 7, 2011. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director, Wellness Director, and staff were re-educated to our policy and procedure concerning our reporting requirements via the ALC Decision Tree and state regulation 410 IAC 16.2-5-1.3 (g) (1-6). The Residence Director and/or the Wellness Director will ensure incidents considered reportable are communicated with appropriate personnel as indicated within the ALC Decision Tree and applicable state agencies within 24 hours of occurrence in accordance with 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management. **How will the corrective**	03/11/2011

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	frequently until our new call light stem arrives. Check every resident at least hourly..." During an interview on 2/23/11 at 10:45 a.m., the Wellness Director indicated that none of the call lights in the facility were working and they (the facility) were getting a new sytem and the staff was performing checks on residents. During an interview on 2/23/11 at 11:01 a.m., the Acting Administrator indicated that some of the call lights had stopped transmitting on 2/4/2011 and he ordered a new call light system on 2/8/11. During an interview on 2/23/11 at 11:15 a.m., the Wellness Director indicated that staff was to check on residents every 1/2 hour to 1 hour and this was recorded in the Communication book that is read by the staff. When asked how residents were to call for help while the call light system was not working, the Wellness Director stated, "I guess they wouldn't be able to." During an interview on 2/23/11 at 11:36 a.m., the Wellness Director indicated that not all rooms have phones and it is the choice of the residents and the residents must pay for phones. She indicated there was only 1 resident in the facility who did		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Wellness Director will perform an ongoing daily review of incidents to ensure continued compliance with applicable state reporting guidelines as indicated by state ruling 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/11/11	

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	not have a phone in the room. She indicated that signs were being posted on 2/23/11 in resident rooms that displayed a phone number for residents to call for assistance and she would provide a list of residents whom she believed would not be able to use a phone due to impaired cognition. She indicated that most residents do not usually use call lights in the facility. During an interview on 2/23/11 at 2:00 p.m., the Acting Administrator indicated he could not find any record of Indiana State Department of Health being notified the call light system was not functioning. He indicated families of residents had not been notified the call light system was not functioning and they (staff) would notify families that evening. He indicated the new call light system would ship from the supplier on Friday, 2/25/2011, and would arrive at the facility the following Wednesday. During an interview on 2/23/11 at 2:20 p.m., the Acting Administrator provided a copy of the purchase order for the new call light system with an order date of "2/23/2011" printed on the purchase order.			

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R0185	Based on observation, interview and record review ,the facility failed to ensure that residents were able to summon for help using the facility call system. This was discovered during the testing of Resident #1's call system and affected all residents in the facility. Findings included: The record for Resident # 1 was reviewed on 2/21/11 at 2:30 p.m. Diagnoses for Resident # 1 included, but were not limited to, depression, suicidal ideation, hypertension, peripheral vascular disease, kidney stone, dementia and Alzheimer's disease. On the following date and time, the following observation was made: 2/23/11 at 9:50 a.m. - Resident # 1 was in her room sitting in a chair watching television. The room contained two call lights with pull strings attached. One call light was on the wall at the head of the bed and the second call light was located in the bathroom. The resident indicated that she didn't think the call lights were working. The call light by the bed was activated by this surveyor at 10:24 a.m. This surveyor exited Resident # 1's room	R0185	**Citation #2** **R 185** **410 IAC 16.2-5-1.6 (i) (1-2) (A) (i-iii) (B-E)** **Physical Plant Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The call light system was replaced and operational on March 7, 2011. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director, Wellness Director, and staff were re-educated to state ruling 410 IAC 16.2-5-1.6 (i) (1-2) (A) (i-iii) (B-E) and our policy and procedure concerning the ALC Decision Tree. The Residence Director and/or Wellness Director will ensure going forward the Regional team is consulted in the event of a physical plant issue or state reportable event for appropriate	03/07/2011

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	at 10:40 a.m., and waited in the hall outside of the resident's room until 10:45 a.m. Staff did not respond to the call light. A document, dated 2/4/11, from the Staff Communication book provided by the Wellness Director on 2/23/11 at 2:30 p.m., included, but was not limited to, the following: "Attention staff please check residents frequently until our new call light stem arrives. Check every resident at least hourly..." Nursing notes for Resident # 1, dated 1/17/2011 through 2/11/11, did not indicate that hourly resident checks were completed. During an interview on 2/23/11 at 10:45 a.m., the Wellness Director indicated that none of the call lights in the facility were working and they (the facility) were getting a new sytem and the staff was performing checks on residents. During an interview on 2/23/11 at 11:01 a.m., the Acting Administrator indicated that some of the call lights had stopped transmitting on 2/4/2011, and he ordered a new call light system on 2/8/11.		follow up and intervention. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Wellness Director will conduct an ongoing daily review of incidents to ensure continued compliance with state ruling 410 IAC 16.2-5-1.6 (i) (1-2) (A) (i-iii) (B-E) Physical Plant Standards. Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/7/11	

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	During an interview on 2/23/11 at 11:15 a.m., the Wellness Director indicated that staff were to check on residents every 1/2 hour to 1 hour and this was recorded in the Communication book that is read by the staff. When asked how residents were to call for help while the call light system was not working, the Wellness Director stated, "I guess they wouldn't be able to." During an interview on 2/23/11 at 11:36 a.m., the Wellness Director indicated that not all rooms have phones and it is the choice of the residents and the residents must pay for phones. She indicated there was only 1 resident in the facility who did not have a phone in the room. She indicated that signs were being posted on 2/23/11 in resident rooms that displayed a phone number for residents to call for assistance and she would provide a list of residents whom she believed would not be able to use a phone due to impaired cognition. She indicated that most residents do not usually use call lights in the facility. During an interview on 2/23/11 at 2:20 p.m., the Acting Administrator provided a copy of the purchase order for the new call light system with an order date of "2/23/2011" printed on the purchase			

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	order. He indicated the facility does not have a policy regarding use of call lights for the facility.			

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R0302	Based on observation, record review and interview, the facility failed to ensure over the counter medications were properly labeled and 'First Open' dates were marked for medications with expiration dates dependent upon date the medication was opened. This affected 2 of 10 residents (Residents # 9, #3) whose medications were in need of a first open date and for 5 of 5 residents who received over the counter medications. (Residents #9, #3, #2, #4, #5) Findings Included: During and observation of Medication Cart on 2/22/11 at 4:00 p.m., and in the presence of QMA # 2, 6 opened bottles of eye drops, all 6 bottles of eye drops were reviewed for a date in which they were opened and given to a resident. The bottles belonged to the following residents: Resident # 9 - 3 bottles and Resident # 3 - 3 bottles. These medications were without first opened dates. Over the Counter (OTC) medications were observed in the Medication Cart. The medications did not include the resident ' s full name, physician name and/or room number. The medications were labeled with only a name or a room	R0302	**R 302 410 IAC 16.2-5-6 (c) (6) Pharmaceutical Services What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and licensed staff were re-educated to state ruling 410 IAC 16.2-5-6 (c) (6) Pharmaceutical Services. The Wellness Director is to ensure going forward OTC medications are appropriately labeled with the following: (1) first opened dates (2) expiration date (3) resident name (4) room number (5) physician name (6) directions for usage per MD order. . **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will ensure continued compliance through weekly	03/11/2011

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	number. Medications included: Mature Vitamin- name and room number, belonging to Resident # 3 Caltrate- name only, belonging to Resident # 3 Aspirin 81mg- belonging to Resident # 3 Tylenol- room number, belonging to Resident # 3 Iron- no name or room number, only the words "AM/PM", belonging to Resident # 2 Wal-zyr (generic or "store brand" Zyrtec)- name and room number, belonging to Resident # 2 Stool Softener (generic/store brand)- directions on how to give and "PM" written on the bottle, belonging to Resident # 9 Tylenol- room number only, shared between Residents # 4 & 5 who are a married couple. Review of a facility policy dated 2005, titled "Policy: Packaging and Labeling" indicates that over the counter medications must be identified with the following: Resident's Full Name, Physician's name, Expiration date, Name		review of medications within the medication cart for properly labeled OTC medications per our policy and procedure and state ruling 410 IAC 16.2-5-6 (c) (6). Findings will be reviewed and corrected through our QA process. **By what date will the systemic changes be completed?** Compliance Date: 3/11/11	

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	of drug, Strength of drug. During an interview with Qualified Medication Aide (QMA) #2 on 2/22/11 at 4:15 p.m., she indicated that they can identify who the over the counter medication is for by the name or room number written on the bottle."			